MDR Tracking Number: M5-05-1776-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The disputed dates of service 2-23-04 and 2-24-04 are untimely and ineligible for review per TWCC Rule 133.308 (e)(1) which states that a request for medical dispute resolution shall be considered timely if it is received by the Commission no later than one year after the dates of service in dispute. This dispute was received on 2-25-05.

The IRO reviewed office visits, therapeutic exercises, electrical stimulation, and massage from 3-1-04 to 1-14-05.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. The IRO deemed the office visit 99214 on 3-10-04 to be medically necessary in the amount of $92.30 as requested. (Note: The MAR is $77.53 x 125% = $96.91). The IRO agreed with the previous adverse determination that the other office visits, therapeutic exercises, electrical stimulation, and massage were not medically necessary. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO Decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division. On 3-17-05, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Code 99080-73 billed for dates of service 11-30-04 and 12-29-04 was denied as "V – unnecessary medical"; however, per Rule 129.5, the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. The TWCC-73

was submitted according to the rule; therefore, recommend reimbursement of $15.00 x 2 days = $30.00.

ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay $107.30 of the unpaid medical fees outlined above for dates of service 3-10-04,11-30-04, and 12-29-04:

- In accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c);

- In accordance with TWCC reimbursement methodologies regarding Work Status Reports for dates of service on or after August 1, 2003 per Commission Rule 134.202 (e)(8);

- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order.

This Order is hereby issued this 11th day of May 2005.

Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive Austin, Texas 78738

Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 4/18/05

TWCC Case Number:	
MDR Tracking Number:	M5-05-1776-01
Name of Patient:	
Name of URA/Payer:	Network of Physicians Mgmt.
Name of Provider: (ER, Hospital, or Other Facility)	Network of Physicians Mgmt.
Name of Physician: (Treating or Requesting)	Mark W. Crawford, DC

April 12, 2005

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating

physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Texas Workers Compensation Commission

CLINICAL HISTORY

Documents Reviewed Included the Following:

1. Notification of IRO Assignment, Table of Disputed Services and Carrier EOBs
2. Independent medical evaluation and reports, dated 2/28/01 and 6/14/04
3. Peer reviews, dated 05/01/02, 12/19/02, 10/7/03, 6/21/04, and 10/3/04
4. Copies of CMS-1500 billings
5. Treating doctor's patient daily records, "Patient NOTES Reports," and exercise logs, multiple dates, ranging from 2/23/04 through 1/14/005
6. MRI lumbar spine report, dated 04/28/04
7. Medical pain management services narrative report, dated 6/2/04
8. Orthopedic surgeon narrative reports, dated 7/7/04 and 12/3/04
9. Operative report, 8/30/04
10. TWCC-73s

Patient is an unknown-aged male who, on ___, lifted a pipe and injured his lower back. Following nearly 2 years of chiropractic treatment and physical therapy, on 01/03/02 he underwent hemilaminectomies at L5-S1 and L4-5 with facetectomy and perineural neurolysis at L5-S1, followed by post-surgical rehabilitation. When these treatments failed, he underwent surgical fusion on 6/16/2003, followed again by post-operative rehabilitation. The patient continued

to have symptoms, so a trial of injections then ensued which again proved unsuccessful. Finally, a third surgical procedure occurred on 8/30/04 that consisted of pseudoarthrosis removal, as well as a fusion "re-do," followed by additional post-operative rehabilitation. Throughout this 5-year time frame, the patient continued to receive chiropractic care, supervised rehabilitation, and medical pain management.

REQUESTED SERVICE(S)

Established patient office visits, levels II, III and IV (99212, 99213 and 99214), established patient office visits, level III, with separate identifiable E/M service (99213-25), therapeutic exercises (97110), electrical stimulation, unattended (G0283), and massage therapy services (97124) for dates of service 3/1/04 through 1/14/05.

DECISION

The established patient office visit, level IV (99214) on date of service 3/10/04 is approved.

All remaining services and procedures are denied.

RATIONALE/BASIS FOR DECISION

In the records submitted for review in this case, only one examination was provided for review (3/10/04), so this was supported as medically necessary.

However, in terms of the remainder of the services rendered in this case, adequate documentation was not supplied to support medical necessity. For example, the reexamination performed on 3/10/04 revealed that the patient's lumbar flexion was restricted to 41 degrees, extension was limited to 22 degrees, and right and left lateral flexion were 18 and 21 degrees each, respectively. But, there was no subsequent range of motion testing subsequently supplied to determine whether the treatment that was being rendered was providing functional benefit or not.

Physical medicine is an accepted part of a rehabilitation program following an injury or surgery. However, for medical necessity to be established there must be an expectation of recovery or improvement within a reasonable and generally

predictable time period. In addition, the frequency, type and duration of services must be reasonable and consistent with the standards of the health care community. General expectations include: (A) As time progresses, there should be an increase in the active regimen of care, a decrease in the passive regimen of care and a decline in the frequency of care. (B) Home care programs should be initiated near the beginning of care, include ongoing assessments of compliance and result in fading treatment frequency. (C) Patients should be formally assessed and re-assessed periodically to see if the patient is moving in a positive direction in order for the treatment to continue. (D) Evidence of objective functional improvement is essential to establish reasonableness and medical necessity of treatment. In this instance, however, there was no documentation of objective or functional improvement in this patient's condition, and no evidence of a change of treatment plan to justify additional treatment in the absence of positive response to prior treatment. Therefore, expectation of functional restoration was not reasonable based on prior lack of success.

In addition, the records did not just lack any submitted documentation establishing medical necessity, they also failed to establish any over-all improvement in the functional status as it pertained to returning this patient to work. There was also no provided end-point for further treatment, any notation for review that outlined plans to reduce treatment frequency and/or return the patient to work that would otherwise substantiate the need for these services.

Furthermore, the *Guidelines for Chiropractic Quality Assurance and Practice Parameters*[1] Chapter 8 under "Failure to Meet Treatment/Care Objectives" states, "After a maximum of two trial therapy series of manual procedures lasting up to two weeks each (four weeks total) without significant documented improvement, manual procedures may no longer be appropriate and alternative care should be considered." Yet, in this case, despite a lack of documented response, the treatment plan remained unaltered for months and months.

[1] Haldeman, S; Chapman-Smith, D; Petersen, D *Guidelines for Chiropractic Quality Assurance and Practice Parameters,* Aspen Publishers, Inc.

And finally, the records revealed that the patient was engaged in primarily stretching, walking and floor exercises that could easily have been performed at home. On the most basic level, the provider failed to establish why the services were required to be performed one-on-one (continuously supervised) when current medical literature states, "…there is no strong evidence for the effectiveness of supervised training as compared to home exercises."[2]

[2] Ostelo RW, de Vet HC, Waddell G, Kerchhoffs MR, Leffers P, van Tulder M, Rehabilitation following first-time lumbar disc surgery: a systematic review within the framework of the cochrane collaboration. Spine. 2003 Feb 1;28(3):209-18.